

Client Name \_\_\_\_\_

Page 1

|   |  |                                    |                |                |
|---|--|------------------------------------|----------------|----------------|
| Site location: _____  |  | Service provider: _____            |                | Date: _____    |
| Name: _____   |  |                                    |                |                |
| FIRST   |  | MI                                 |                | LAST           |
| Nickname, if any _____  |  |                                    |                |                |
| <u>Mailing Address:</u> _____   |  |                                    |                |                |
| City _____  |  | State _____                        |                | Zip Code _____ |
|   |  |                                    |                |                |
| <u>Street Address:</u> _____  |  |                                    |                |                |
| City _____  |  | State _____                        |                | Zip Code _____ |
| Birth date _____  |  | _____ Female _____ Male            |                |                |
| Telephone Number(s)   |  |                                    |                |                |
| Home  |  | cell or message                    |                |                |
| (____)____-____   |  | (____)____-____                    |                |                |
| In the past year, have you received services from more than one Senior Center in Wyoming? _____ NO _____ YES                      |  |                                    |                |                |
| • If yes, where: _____  |  |                                    |                |                |
| • Did you complete this form and sign a Release at that site? _____ NO _____ YES  |  |                                    |                |                |
| Do you have difficulty reading or writing? _____ NO _____ YES   |  |                                    |                |                |
| Do you require an interpreter or reader? _____ NO _____ YES   |  |                                    |                |                |
| <b>Emergency Contact Information</b>  | Name of Emergency Contact Person _____ |                                    |                |                |
|   | Mailing Address _____                  |                                    |                |                |
|   | City _____                             |                                    |                |                |
|   | State _____                            |                                    | ZIP code _____ |                |
|   | Telephone number(s) _____              |                                    |                |                |
|   | Relationship to you, if any _____      |                                    |                |                |
| Do you live in a rural area ? _____ NO _____ YES  |  |                                    |                |                |
| (Answer NO, if you live in Casper, Cheyenne, Gillette, Laramie, or Rock Springs. All other areas of state should be marked rural) |  |                                    |                |                |
| Language spoken   |  | Marital Status                     |                |                |
| _____ English _____ Spanish   |  | _____ Single/Widowed _____ Married |                |                |
| _____ Russian _____ Other   |  | Spouse Name _____                  |                |                |
| _____ Native American _____ Asian   |  | Spouse Birth date _____            |                |                |
| Please list other: _____  |  |                                    |                |                |

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|  |   |
|--|---|
| Do you live alone ____NO ____YES   | Are you a veteran? ____NO ____YES<br>(served active duty and honorably discharged)<br>Are you a spouse or dependant of a veteran?<br>____NO ____YES                                       |
| Race<br>____White ____Black/African American<br>____Asian, Specify nationality____<br>____Native American____Pacific Islander<br>____Other, please list_____   | Ethnicity<br>____Hispanic/Latino<br>Other, please specify: _____  |
| Are you a caregiver ____No ____Yes<br>Is the person you give care to: (a) over 60<br>(b) have Alzheimer's or Dementia (c) an<br>adult with disabilities or (d) a minor child 18<br>or younger ____No ____Yes | Do you have a<br>heart condition? ____NO ____YES<br>Do you have diabetes? ____NO ____YES  |
| Person you care for: _____<br>Address _____<br>Phone Number _____<br>Date of Birth _____<br>Gender ____Female ____Male<br>Relationship to You _____  | Have you ever had a<br>pneumonia shot? ____NO ____YES<br><br>Have a flu shot this year? ____NO ____YES<br><br>Have you received information about the<br>shingles vaccine? ____NO ____YES |
|  | Is your family gross annual income at or<br>below this amount ____NO ____YES<br>FAMILY SIZE 1 - \$10,890 FAMILY SIZE 3 - \$18,530<br>FAMILY SIZE 2 - \$14,710 FAMILY SIZE 4 - \$22,350    |

**Nutritional Risk Assessment (Please Circle Yes or No)**

|   |                    |                   |
|---|--------------------|-------------------|
| I have an illness or condition that changes the kind or amount of food I eat. | Yes <sub>(2)</sub> | No <sub>(0)</sub> |
| I eat fewer than two (2) meals per day.                                       | Yes <sub>(3)</sub> | No <sub>(0)</sub> |
| I eat fewer than 5 servings (1/2 cup each) of fruits or vegetables daily.     | Yes <sub>(1)</sub> | No <sub>(0)</sub> |
| I eat/drink fewer than two servings of dairy (milk/cheese) products daily.    | Yes <sub>(1)</sub> | No <sub>(0)</sub> |
| I have 3 or more drinks of beers, wine or hard liquor every day.              | Yes <sub>(2)</sub> | No <sub>(0)</sub> |
| I have tooth, mouth or swallowing problems that make it difficult to eat.     | Yes <sub>(2)</sub> | No <sub>(0)</sub> |
| I eat alone most of the time.   | Yes <sub>(1)</sub> | No <sub>(0)</sub> |
| I take 3 or more different prescribed or over-the-counter medications daily.  | Yes <sub>(1)</sub> | No <sub>(0)</sub> |
| I am not always able to shop, cook and/or feed myself.                        | Yes <sub>(2)</sub> | No <sub>(0)</sub> |
| I have unintentionally lost or gained 10 pounds in the past 6 months.         | Yes <sub>(2)</sub> | No <sub>(0)</sub> |
| Sometimes, I do not have enough money to buy food.                            | Yes <sub>(4)</sub> | No <sub>(0)</sub> |

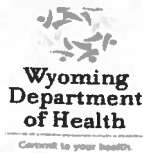
**Nutritional Risk Score:** \_\_\_\_\_

**High Risk – 6 or more points Moderate Risk - 3-5 points Low Risk – 0-2 points**

Type of evaluation: Initial evaluation: B/C1/ D: C2/Care Receiver/CBIHS/ B (IHS)

Re-evaluation: B/C1/ D: C2/Care Receiver/CBIHS/ B (IHS)

PERSON REVIEWING FORM: \_\_\_\_\_



AGING DIVISION – DOCUMENT 07-01-2011  
AGING NEEDS EVALUATION SUMMARY (AGNES)

Client Name \_\_\_\_\_

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**RELEASE OF INFORMATION**

I hereby give my permission for \_\_\_\_\_ [SERVICE PROVIDER] to share information contained in the AGING NEEDS EVALUATION SUMMARY and other program documentation with the Aging Division and other affiliated service providers for the purpose of eligibility for the Administration on Aging and State of Wyoming grant programs such as supportive services, congregate meals, home-delivered meals, preventive services, community in-home services, family caregiver services.

Further, I understand that: By agreeing to take part in this program I give my permission to the service provider(s), Wyoming Department of Health (WDH), Aging Division, and the Administration on Aging (AoA) to share information obtained for the purpose of program evaluation and oversight.

Information received will be treated as **confidential** and will only be made available in accordance with the requirements of law.

I may cancel this release at any time except to the extent that action has been taken in reliance on it, and that in any event this release expires automatically one year from the date of my signature.

If I do not sign this release for the purposes described above, I may be required to pay for any services I have received or be solely responsible for payment of services.

If I am denied program services, I may be entitled to a hearing.

I have the right review and/or obtain a copy of my record including an accounting of any disclosures made from my record.

If I feel information in my record is invalid, I may make a written request for an amendment of the record. I have been provided a copy of this form.

If I feel I have been treated inappropriately, services have not been of the quality expected and/or not provided as stated in the service plan; I may contact the Wyoming Long Term Care Ombudsman at (800)-856-4398 or the WDH Aging Division at (800) 442-2766. For additional information regarding the Wyoming Department of Health's privacy policy, visit the WDH Department's HIPAA website: <http://www.health.wyo.gov/main/hipaa.html> or call De Anna Greene, WDH HIPAA Compliance Officer at (307) 777-8664.

**Client or Representative's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Authority and Relationship of Representative (if any) to sign on Client's behalf**

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nutritional Risk Score**

0-2 Low Risk

3-5 Moderate Risk

6 or more High Risk

**-Nutrition Risk Action**

- Recheck in 12 months

- Recheck in 3-6 months, Provide "Eating Well as We Age Brochure" or similar information.

- Recommend to client that he or she discuss their nutritional risk score with their health professional or dietitian. Client is at high nutritional risk.

**PROVIDER/AGING DIVISION COPY - AGNES 07012011**

**Make copy for client after signed**



**Activities of Daily Living (ADL's)**

**Rate client's ability to perform BATHING. (Include shower, full tub or sponge bath, exclude washing back or hair.)**

- 0 Independent
- 2 Intermittent supervision or minimal physical assistance (stand by assistance)
- 4 Partial assistance (can perform some but not all of the bathing activity)
- 6 Total dependence

**Rate client's ability to EAT.**

- 0 Independent
- 2 Limited assistance (need assistive devices or minimal physical assistance)
- 4 Extensive help (client needs continuous cueing, assistance or supervision)
- 6 Total dependence

**Rate client's ability to perform DRESSING.**

- 0 Independent
- 1 Limited physical assistance (help with zippers, buttons and adjusting clothing)
- 2 Reminding, cueing or monitoring
- 3 Extensive assistance
- 4 Total dependence

**Rate client's ability to perform TOILETING.**

- 0 Independent
- 2 Reminding, cueing or monitoring
- 4 Limited physical assistance (help adjusting clothing or incontinence supplies)
- 6 Extensive assistance (wiping, cleaning or changing)
- 8 Total dependence

**Rate client's ability to perform TRANSFER.**

- 0 Independent
- 1 Limited physical assistance (includes assistive devices, i.e. walkers and canes)
- 2 Extensive assistance (care provider uses assistive devices, gait belt, etc)
- 3 Total dependence

**Rate client's mobility IN HOME.**

- 0 Independent
- 1 Limited Physical Assistance (includes assistive devices, walkers and canes)
- 2 Extensive Assistance (includes assistive devices, gait belt, wheelchair)
- 3 Total dependence

**Instrumental Activities of Daily Living (IADL's)**

**Rate client's ability to PREPARE MEALS**

- 0 Independent OR Prepares simple or partial meals (frozen, ready-made food, cereal, sandwich)
- 1 Prepares with verbal cueing or reminding
- 2 Prepares with minimal help (cut, open or set up)
- 3 Does not prepare any meals

**Rate client's ability to perform SHOPPING.**

- 0 Independent
- 2 Does with supervision, verbal cueing or reminders
- 4 Shops with hands-on help or assistive devices
- 6 Done by others or shops by phone

**Rate client's ability to MANAGE MEDICATIONS.**

- 0 Independent
- 2 Done with help some of the time
- 4 Done with help all of the time

**Rate client's ability to MANAGE MONEY.**

- 0 Completely independent
- 2 Needs assistance sometimes
- 4 Needs assistance most of the time
- 6 Completely dependent

**Rate client's ability to USE THE TELEPHONE.**

- 0 Independent
- 1 Can perform with some human help
- 2 Cannot perform function at all without human help

**Rate client's ability to perform HEAVY HOUSEWORK.**

- 0 Independent
- 1 Needs assistance sometimes
- 2 Does with maximum help
- 3 Unable to perform tasks

**Rate client's ability to perform LIGHT HOUSEKEEPING.**

- 0 Independent
- 1 Needs assistance sometimes
- 2 Needs assistance most of the time
- 3 Unable to perform tasks

**Rate client's ability to access TRANSPORTATION.**

- 0 Independent
- 1 Done with help some of the time
- 2 Done by others
- 3 Requires ambulance

**Quarter period** \_\_\_\_\_.

**ADL TOTAL NUMBER** \_\_\_\_\_.

**ADL TOTAL SCORE** \_\_\_\_\_.

**Client Initial** \_\_\_\_\_.

**Date** \_\_\_\_\_.

**IADL TOTAL NUMBER** \_\_\_\_\_.

**IADL TOTAL SCORE** \_\_\_\_\_.

**ACC Initial** \_\_\_\_\_.



| No | Yes | <b><u>CBIHS INFORMATION</u></b><br><b><u>HOME VISIT EVALUATION</u></b> |
|----|-----|--|
|    |     | Safe access to all necessary areas of home?                            |
|    |     | Electrical hazards in home?  |
|    |     | Dangers on stairs or floors  |
|    |     | Cluttered/soiled living area   |
|    |     | Inadequate sewage disposal   |
|    |     | Inadequate/improper food storage                                       |
|    |     | Insects/rodents present  |
|    |     | Indoor toileting facilities  |
|    |     | Does client have trash removal service                                 |
|    |     | Outdoor toileting  |
|    |     | Problems with locks on doors and windows                               |
|    |     | Hard to get in and out of bathroom                                     |
|    |     | Do kitchen appliances work properly                                    |
|    |     | Problems with water/hot water/plumbing issues                          |
|    |     | Home temperature able to be controlled                                 |
|    |     | Functioning clothes washer   |
|    |     | Functioning clothes dryer  |
|    |     | Functioning telephone/cell phone                                       |
|    |     | Outside steps and walkways in good repair                              |
|    |     | Does person feel safe in the neighborhood                              |
|    |     | Pets in home   |
|    |     | Adequate food for pets   |
|    |     | Is client able to exit safely in an emergency                          |
|    |     | Does client need assistance to exit in an emergency                    |
|    |     | Fire hazards in home (frayed cords, items next to heater)              |
|    |     | Smoke detectors installed in home (need batteries?)                    |
|    |     | Carbon monoxide detectors in home (need batteries?)                    |
|    |     | Free from odors and pests  |
|    |     | Other hazards noted:   |

Comments or Notes:

Directions to the clients home for services for home services?

SPECIAL DIET:

**ELIGIBILITY CHECKLIST**

| No | Yes | <u>Check all answers that apply:</u><br><u>Home bound, eligibility for</u><br><u>Home delivered meals, CBIHS</u><br><u>or other in home services (Title</u><br><u>III B)</u> |
|----|-----|--|
|    |     | Person homebound because of geographical isolation (outside the boundaries of public transportation service area.)   |
|    |     | Homebound on recommendation of medical practitioner.   |
|    |     | Homebound due to frail health, illness or disability.  |
|    |     | Homebound due to mental or social limitations or isolation.  |
|    |     | Homebound - other reason, list   |
|    |     | ADL (number 2 or more)   |
|    |     | IADL (number 2 or more)  |
|    |     | Other reasons: List  |



Client Name \_\_\_\_\_

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- 6 Total dependence

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- 0 Independent
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